



FIG. 1

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Registration - Basic Information 1

Basic Information 1	Basic Information 2
Agency: 100	Case Number: 12345
a. Caller's First Name: Paul	Middle Name: Last Name: Peterson
b. Phone Number: (212)-999-9999	c. Are you having trouble with your vision? Yes 25
1. If No, Specify why they called:	
d. Relationship to person that is visually impaired: 1. Self	
e. VIP First Name: Paul	Middle Name: Last Name: Peterson
f. Phone Number: (212)-821-0375	g. What is your biggest problem now? 26
1. If other, Specify other biggest problem:	
h. (Consumer Status: Not to be asked aloud) Is person in crisis? 28	
If Yes, based on conversation and "biggest problem", checking any of the following indicates a crisis:	
<div style="display: flex; justify-content: flex-end;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">Homeless</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">Suicidal</div> <div style="border: 1px solid black; padding: 2px;">Homicidal</div> </div>	
If No, based on conversation and "biggest problem", checking any of the following indicates an Urgency:	
<div style="display: flex; justify-content: flex-end;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">Burning Self</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">Falling</div> <div style="border: 1px solid black; padding: 2px;">May lose Job</div> </div>	
30	
Next Page 34	Save 34
	Close 32

FIG. 2

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Triage Page 1 - Demographics

VIP First Name: Martin Last Name: YABLONSKI Case Number: LH99911

Total Episode Number: 1 Current Episode Number: 1

Page 5 - Risk Factors	Page 6 - Recommendations	Page 7 - Eye Report/Filing Triage	Page 8 - 7-08
Page 1 - Demographics	Page 2 - Health	Page 3 - Problem ID	Page 4 - Problem ID

Staff: Yablonski, Martin

1. DEMOGRAPHICS

a. Sex: M b. Date of Birth: 12/22/51 c. Age: 51

d. Are you a US citizen or a legal resident? Yes

1. If No, would you like to speak with someone to help you become a legal resident? 40

e. Which of the following categories do you use to identify yourself?

16. Puerto Rican
 17. Samoan
 18. Vietnamese
 19. White

2. VISION STATUS

a. Can you recognize faces across a room? Yes

b. Can you recognize faces at arms length? 48

c. Do you have any vision? No

d. At what age did vision loss begin to limit your functioning? 12/1/2002

e. Do you wear glasses or use other optical devices? No

f. When did you last see your eye doctor? No

g. Has your vision changed since that time?

New Episode Previous Page Next Page Save Close
 54 50 48 46 52

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FIG. 3

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Triage Page 3 - Problem ID

VIP First Name: Paul Last Name: Peterson Case Number: 12345

Total Episode Number: 0 Current Episode Number: 1

Page 5 - Risk Factors	Page 6 - Recommendations	Page 7 - Eye Report/Filing Triage	Page 8 - 7-OB
Page 1 - Demographics	Page 2 - Health	Page 3 - Problem ID	Page 4 - Problem ID

4. Problem Identification

As a result of your vision impairment, are you having problems in the following areas?

If you receive a "yes" answer to any questions move on to the next area unless otherwise specified. A "yes" prompts a recommendation for assessment in that area.

VISUAL FUNCTIONING PROBLEMS

1. Are you having trouble reading newsprint? Yes ▾

2. Seeing a TV, computer screen or street sign? ▾

MOVEMENT/MOBILITY PROBLEMS

1. Have you fallen in the last 6 months? No ▾

2. Are you having trouble moving around your home (such as bumping into things), your neighborhood, at work, or using buses or subways? ▾

HOUSEHOLD ACTIVITY PROBLEMS

1. Writing (e.g. correspondence, checks, etc.)? Yes ▾

2. Cooking, preparing food, shopping, cleaning, or doing laundry? ▾

New Episode Previous Page Next Page Save Close

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FIG. 4

Triage Page 6 - Recommendations

VIP First Name: Paul Last Name: Peterson Case Number: 12345

Total Episode Number: 0 Current Episode Number: 1

Page 1 - Demographics Page 2 - Health Page 3 - Problem ID Page 4 - Problem ID
Page 5 - Risk Factors **Page 6 - Recommendations** Page 7 - Eye Report/Filing Triage Page 8 - 7-OB

Mark each recommended area with (Accepted) or (Rejected), and if rejected, a reason. Instructions for Recommendations

<input type="checkbox"/> Social Services	VIP will	<input type="text"/>	Rejection Reason:	<input type="text"/>
<input checked="" type="checkbox"/> Low Vision	VIP will	Accepted	Rejection Reason:	<input type="text"/>
<input type="checkbox"/> Diabetes Management	VIP will	<input type="text"/>	Rejection Reason:	<input type="text"/>
<input type="checkbox"/> Insulin Device Training	VIP will	<input type="text"/>	Rejection Reason:	<input type="text"/>
<input type="checkbox"/> Psychotherapy	VIP will	<input type="text"/>	Rejection Reason:	<input type="text"/>
<input checked="" type="checkbox"/> Independent Living Therapy	VIP will	Accepted	Rejection Reason:	<input type="text"/>
<input type="checkbox"/> Mobility Therapy	VIP will	<input type="text"/>	Rejection Reason:	<input type="text"/>
<input type="checkbox"/> Children's Services	VIP will	<input type="text"/>	Rejection Reason:	<input type="text"/>
<input type="checkbox"/> Computer Skills	VIP will	<input type="text"/>	Rejection Reason:	<input type="text"/>
<input type="checkbox"/> Employment	VIP will	<input type="text"/>	Rejection Reason:	<input type="text"/>
<input type="checkbox"/> Academic Skills	VIP will	<input type="text"/>	Rejection Reason:	<input type="text"/>
<input type="checkbox"/> Reading Service	VIP will	<input type="text"/>	Rejection Reason:	<input type="text"/>
<input type="checkbox"/> Music School	VIP will	<input type="text"/>	Rejection Reason:	<input type="text"/>

Specify other rejection reason:

If no recommendations are accepted, outcome reason:

New Episode Previous Page Next Page Save Close

Handwritten annotations: 64, 60, 62, 66, 76, 72, 70, 68, 74

FIG. 5

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Triage Page 7 - Filing Triage

VIP First Name: Paul Last Name: Peterson Case Number: 12345
Total Episode Number: 0 Current Episode Number: 1

Page 1 - Demographics	Page 2 - Health	Page 3 - Problem ID	Page 4 - Problem ID
Page 5 - Risk Factors	Page 6 - Recommendations	Page 7 - Eye Report/Filing Triage	Page 8 - 7-OB

If ANY recommendations are accepted, EYE REPORT must be requested. Service Instruction

Eye Doctor's First Name: Last Name: Phone Number:

Have you had eye surgery or laser treatments in the last six months? ☐ If Yes, please specify when?

Closure Narrative: 80

Consumer Status: 82 Service Location: 84

Appointments 86
Make assessment appointments in each accepted area. Instruct consumer to bring any eyeglasses or optical devices to appointments. Appointments Instruction 88

Alternate Contact Name: Phone Number: Triage End Date:

Episode Outcome: 94

Episode Close Date: 94

New Episode Previous Page Next Page Save Done

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FIG. 6

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Visual and Medication Information

VIP Name: Paul Peterson Address: 111 East 59th Street, New York, NY 10022

Case Number: 12345 Total Record Number: 0 Current Record at position: 0

Staff Name: 98 The information checked at Date:

Diagnosis Source:

Primary Diagnosis:

Secondary Diagnosis:

Acuity Source: OD

Visual Acuity: OS OU

Field Source:

Visual Field: OD OS

Other Medical Conditions: Allergies
Arthritis/Rheumatism
Brain Injury/Diseases
Cancer

Length of time living at current address:

100
Current Medications, dosages and frequency:

Information for Glasses or Devices

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☐ CCTV Description ☐ Magnifier Description
☐ Spectacles ☐ Telescope: Monocular Strength/Description
☐ Spectacles (Prism) ☐ Telescope: Binocular Strength/Description
☐ SUN wear tint/brand ☐ Other Description

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New Record | Next Record | Previous Record | Save | Close

FIG. 7

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Payer

Name: Case Number: Current Episode Number:

Payer Name: Payer Location:

Consumer ID with Payer: Payer Contact: Phone Number:

Authorization Number: Intervention:

Authorization Start Date: Authorization End Date: Intervention Start Date (display only):

Total Number of Payers: Total Number of Authorizations:

New Payer Save Close

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FIG. 8

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Independent Living Assessment

VIP Name: Smith Mary Address: 111 East 59th Stet New York, NY 10022
 Phone Number: (212) 821-8200 Case Number: 11111 Episode: 1
 Intervention: IL Assessment Total IL Assessment Records: 1 Current Record: 1

Page 9 Observe & Inform Consumer	Page 10 Learning Strategies & Factors	Page 11 IL Service Agreement	
Page 5 Measurement	Page 6 Scanning Skills	Page 7 Safety & Cooking	Page 8 Observe & Inform Consumer
Page 1 Media for Reading/Writing	Page 2 Media for Reading/Writing	Page 3 Organization & Differentiating Skills	Page 4 Organization & Differentiating Skills

Assessor's Name: Kaplin, Anne Independent Living Assessment Date:

To find out Client's health and eye information, please click next button Visual and Health Information

Do you use a prosthesis (eye)? ☐ If Yes, Do you have trouble with your prosthesis? ☐ 122

Are you responsible for caring for others, e. g. children or elders? ☐

Prior Lighthouse Independent Living Instruction: Did you receive instruction elsewhere? ☐

Consumer Self-Ratings If the answer to any consumer self-rating question is a 1 or 2, recommend training. If 3 or 4, request a demonstration. If consumer doesn't answer or indicates they are uninterested in performing a task, mark as "R" refused. Consumer Self-Rating

1. Within the last two weeks, how much difficulty have you had reading your mail?

2. Within the last two weeks, how much difficulty have you had writing down information?

Rating Scale - Observe and Train: 1 = major problem, 10 = no problem, N/A 1 = Refuses Rating Scale

Consumer demonstrated reading Rating

Consumer demonstrated writing Rating

Use of Low Vision Devices Rating

Use of Regular Print Rating

Agrees to training?

Agrees to training?

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Previous Page	Next Page	Save	Close
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FIG. 9

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Total Episode Number: Current Episode Number:

Page 1 - Demographics	Page 2 - Health	Page 3 - Problem ID	Page 4 - Problem ID
Page 5 - Risk Factors	Page 6 - Recommendations	Page 7 - Eye Report/Filing Triage	Page 8 - 7-QB

a. If No, Do you want to learn for personal use?

SOCIAL NEEDS 134

1. How physically active are you on a scale of 1 to 4, where 2. Somewhat active, I move about my home cleaning, etc.

a. If the answer is 1 or 2, is this a change since you lost your vision?

2. How often do you entertain guests or go out with friends?

a. If the answer is 1 or 2, is this a change since you lost your vision?

Risk Factors

<input type="checkbox"/> Abuse	<input type="checkbox"/> Physically Frail	<input type="checkbox"/> Has no payer
<input checked="" type="checkbox"/> Signs of confusion/disorientation	<input type="checkbox"/> Housing Problem	<input type="checkbox"/> Non-supportive network
<input checked="" type="checkbox"/> Developmental delay suspected	<input checked="" type="checkbox"/> Legal Problem	<input checked="" type="checkbox"/> Not willing to pay for services
<input type="checkbox"/> Elderly/isolated	<input type="checkbox"/> Neglect (reported or suspected)	<input type="checkbox"/> Requested Music lessons
		<input type="checkbox"/> Requested Reading Service

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New Episode Previous Page Next Page Save Close

FIG. 10

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Goals Information

Total Number of Goals: 6 Current Goal at Number: 2 Goal: Indoor Travel

Achievement: Date of Achievement:

Goals		
Goal	Achievement	Date of Completion
Sighted Guide	4	08/19/2002
▶ Indoor Travel		
Emergency Exit		
Orientation		
Stairs		
Local Travel		

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Objectives Information

Total number of Objectives: 6 Current Objective: 1 Objective: Trails

Achievement: 3 - somewhat successful Date of Achievement: 08/10/2002

Objectives		
Objective	Achievement	CompletionDate
▶ Trails	3	08/10/2002
Negotiates obstacles	4	08/01/2002
Locate dropped objects	3	07/22/2002
Protective technique		
Vision scanning		
Locate lost items		

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Previous Record | Next Objective | Next Goal | Previous Goal | Save | Clo:

FIG. 11

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Interventions

Total number of Interventions: Intervention Number: Case Number: Episode:

Last Name: First Name: Intervention:

Start Date: Staff Name:

Outcome:

Intervention Narrative:

Post-score of the Provider Rating: Post-score of the Consumer Rating: End Date:

Visits	End of Service Report	Intervention Referral	Next Intervention	Save	Close
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FIG. 12

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If ANY recommendations are accepted, EYE REPORT must be requested.

Service Instruction

Eye Doctor's First Name: Michael Last Name: Gello Phone Number: (212)-234-1874

Have you had eye surgery or laser treatments in the last six months? No If Yes, please specify when ?

182 Closure Narrative: eager to start services as soon as possible 180

Consumer Status: 3. Ordinary Service Location:

Appointments

Make assessment appointments in each accepted area. Instruct consumer to bring any eyeglasses or optical devices to appointments

Appointments

Alternate Contact Name: Jonathon Early Alternate Contact Phone Number: (212)-902-9010

Episode Outcome:

Triage End Date: 6/3/2002 Episode Close Date: 184

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FIG. 13

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End of Episode Survey

Name Case Number ☒ Episode Phone Number

Participant Number Interview Date Interviewer

Please see the LNVRN Manual for the survey

The following questions are regarding NY Lighthouse services in general. Were your appointments made quickly?

Did the NY Lighthouse staff understand your needs?

Were staff helpful?

Did staff show respect for what you had to say?

How often were you involved in decisions about the services you received at NY

Overall, how satisfied were you with NY Lighthouse services? Would you say you were?

(Activity Level) How physically active are you on a scale of 1 to 4.

(Social integration) How often do you entertain guests or go out with friends?

How much have NY Lighthouse services affected your ability to function independently?

Thank you for your time and participation in our survey. We really value your assistance.

Date Completed

Overall Score Save Close

FIG. 14

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